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**OFFICE OF INSPECTOR GENERAL**

*Office of Audits and Evaluations*

VETERANS HEALTH ADMINISTRATION

Management and Oversight  
of the Electronic Wait List for  
Healthcare Services

AUDIT

REPORT #19-09161-02

DECEMBER 1, 2020



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## Executive Summary

The Electronic Wait List is the official tool used by Veterans Health Administration (VHA) medical facilities to manage patient appointments that cannot immediately be scheduled. The wait list allows employees to record, track, and provide reports on patients who are unable to obtain appointments within 90 days at a VA medical facility. It is meant to ensure all veterans who need health care receive it as soon as possible. The wait list also includes administrative entries, such as patients receiving care at one VA facility who are waiting for a transfer to another. Since 2014, VA has posted wait list numbers and data about the wait times for medical appointments on a public website as required by law.<sup>1</sup>

In May 2019, a VHA employee alerted the media and the VA Office of Inspector General (OIG) to allegations that VHA was reporting inaccurate wait list data on VA's public website. The complainant's allegations included that (1) the wait list data did not include entries older than 24 months, and (2) administrative wait list entries from three stop codes (designations for types of clinical work provided) were excluded from public reporting.<sup>2</sup> The OIG conducted this audit to assess those allegations. The audit team also examined whether VHA managed the wait list in accordance with scheduling requirements for veterans' care and whether VA medical facilities complied with wait list management policies.

### What the Audit Found

The OIG substantiated that entries older than 24 months were not visible in the aggregated wait list data as required because VHA had applied a filter that excluded such entries. VHA's Office of Veterans Access to Care (OVAC) personnel explained that the filter was implemented because entries older than 24 months were assumed to be false positives—entries that had been addressed clinically, but never removed from the wait list. However, excluding entries older than 24 months from the wait list hindered VHA's oversight of those entries and their ability to make certain those patients were identified and served, which is the wait list's primary function.

The OIG also confirmed a discrepancy in wait list figures reported on VA's public website (about 11,800 entries) versus what was included in internal data reports (about 37,600 entries) on June 1, 2019. That discrepancy occurred because VHA did not include administrative entries in the publicly reported data.<sup>3</sup> However, federal law does not specifically require administrative

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<sup>1</sup> Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 Stat. 1780, § 206 (2014).

<sup>2</sup> VHA documentation states that stop codes are used to define the type of clinical work or services provided, and for utilization tracking, comparing clinical programs, and performance measures, among other purposes. The three stop codes that were excluded were used to identify administrative entries such as community care consults (referrals), transfer requests, and employee occupational health needs.

<sup>3</sup> VHA policy indicates that the administrative entries were used for patients requesting transfers to other VA facilities, or were waiting for non-VA care.

entries to be reported. The law requires that VA publish wait times for the scheduling of appointments for primary care, specialty care, and hospital care and medical services, but does not distinguish between administrative and clinical wait times and wait list entries.<sup>4</sup> VHA policy also required employees to use the wait list to track administrative entries, but noted “they are not official wait lists” subject to the rules of clinical entries.<sup>5</sup>

### **VA Addressed Differences between Public and Internal Wait Lists**

These issues were also identified by VA’s Office of the Medical Inspector (OMI). In June 2019, OMI reported to Congress that VHA’s publicly reported data differed from internal data reports due to administrative stop codes being excluded from the public reports. OMI’s review also found that the wait list excluded entries older than 24 months. OMI recommended that VHA reevaluate wait list data to determine what stop codes should be included in the publicly reported data and that OVAC ensures clinical entries are included on the wait list regardless of the length of time. VHA began including entries older than 24 months in October 2018 and developed new procedures to manage administrative wait list entries in July and August 2019. Because the audit team determined that VHA removed the 24-month filter, stopped using the wait list to manage administrative entries, and developed new procedures addressing wait list entries, the OIG did not make recommendations specific to this finding.

### **Wait List Entries Were Not Managed Effectively**

In the course of examining the allegations and VA responses related to wait list reporting, the OIG found insufficient oversight of the wait list at the local and national levels, based on analyses of all entries as of June 1, 2019. Lack of oversight creates a risk that patients will not receive care in a timely manner. It also puts patients at risk of being overlooked for appointments or transfers to receive care at their preferred facility and could lead to excess entries on the wait list. The OIG also found wait list entries were not always removed according to established procedures because VA lacked clearly defined oversight controls to ensure entries on the wait list were being reviewed daily by facility employees and validated weekly by supervisors or managers, as required. With proper oversight, veterans like these would be more easily identified and served. When employees do not remove patients from the wait list when appropriate, it creates the appearance that patients were experiencing longer delays in accessing care than is actually the case. Although VHA has made changes to better manage the wait list, the audit team has identified opportunities for additional improvement.

As previously mentioned, there were about 37,600 total entries on the wait list on June 1, 2019. Of those entries, about 25,700 were administrative and about 11,800 were for patients awaiting

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<sup>4</sup> Veterans Access, Choice, and Accountability Act of 2014.

<sup>5</sup> VHA Directive 1230(1), *Outpatient Scheduling Processes and Procedures*, July 15, 2016. Amended on July 12, 2019.

clinical services. Of the 11,800 clinical entries, about 7,200 (61 percent) were older than 30 days. The audit team conducted a statistical sample review of 120 of those older clinical entries and determined that an estimated 5,700 (about 80 percent) had been removed by September 1, 2019, following a qualifying action.<sup>6</sup> A qualifying action meant that the patient received an appointment for care, received care in the community, moved to another location serviced by another medical center, or no longer needed care. Of the estimated 5,700 entries removed, the audit team determined that about 2,400 (42 percent) should have been removed earlier. These entries remained on the wait list an estimated average 277 days after a qualifying action requiring removal occurred, making it appear that patients were waiting longer for care or services than they actually were.

Significantly, there were still some patients who were waiting long periods for care on the list. On January 31, 2020, 14 patients in the audit team's sample had been waiting for an appointment or service for an average of 545 days. Twelve were waiting for home and community-based services, for which facility employees reported delays may be due to limited program resources. The two others were waiting for individual mental health counseling. One of those patients was placed on the wait list in April 2019 and received mental health group counseling in the meantime. The other patient was added to the wait list for individual trauma-focused therapy in April 2019 after the patient opted not to receive care in the community.

### **VHA Required Facilities to Review All Wait List Entries in July 2019**

In July 2019, VHA required facility employees to review all entries from the wait list to address a number of issues, including the removal of administrative entries and determining whether patients were eligible for community care, VA appointment availability, and veteran preference for care.<sup>7</sup> The audit team estimated 3,100 of the 7,200 clinical wait list entries were removed between July 8 and August 31, 2019, indicating that the removals were the result of VA's mandated review. Some waiting patients received appointments during this time, while others received letters asking them to contact the VA regarding their care. Patients who did not respond to VA's letters were removed from the wait list. The audit team found no evidence that VHA employees attempted to contact these patients before the release of the July 8, 2019, memo. For instance, eight patients were on the wait list at one facility for audiology services, but facility employees did not attempt to contact them until July 2019, during the time of the mandated review. Those eight patients were removed after an average of 192 days on the wait list, including one who was on the wait list 359 days before being offered an appointment. The OIG concluded that either there had been no capacity to schedule these patients until July 2019 or

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<sup>6</sup> Figures and percentages have been rounded for reporting purposes. As a result, totals may not always sum.

<sup>7</sup> VHA memo, "MISSION Act Electronic Wait List Initiative and Key Electronic Wait List (EWL) Process Changes (VIEWS# 01338979)," July 8, 2019.

staff had not monitored the wait list to make certain that patients were scheduled as appointments became available.

In July 2019, VHA also required facility employees to review and remove all administrative entries from the wait list. For such entries, VHA employees were to contact veterans and offer a choice to receive care in the community or continue care at their current location. VHA required facility leaders to review and act on their wait list entries by July 19, 2019. Notably, the South Texas Veterans Health Care System in San Antonio accounted for nearly half the administrative wait list entries (11,800 of 25,700), some of which had been there since 2015 and 2016. When employees of this healthcare system eventually reviewed the entries in January 2020, they found about 800 entries of patients without a VA primary care provider assigned in the patients' records. By reviewing patient records and calling patients, these employees determined that about 260 patients had received care outside the system and about 50 other patients' records showed evidence of VA referrals for care in the community. Facility employees were not able to contact the remaining patients, and therefore could not determine if the patients were receiving care. Facility employees later mailed letters to those patients to provide information on receiving VA care and enrollment.

### **VHA Established New Patient Tracking Requirements**

On August 6, 2019, VHA issued a memo that required facilities to remove transfer requests from the wait list and place them on the Light Electronic Administrative Framework (LEAF) tool (another VHA system) for tracking purposes.<sup>8</sup> LEAF replaced the use of the administrative wait lists for transfers and allows for assignment of veterans seeking to transfer care within a healthcare system.

Later, in June 2020, VHA issued another memo to Veterans Integrated Service Network (VISN) directors communicating plans to eliminate the use of the electronic wait list “in an effort to simplify and expedite scheduling of new patients.”<sup>9</sup> According to the memo, VHA plans to use its consult toolbox to identify and track new patients that cannot be timely scheduled, and no longer use the electronic wait list starting December 1, 2020.<sup>10</sup> As VHA moves to eliminate the use of the wait list VHA must have strong oversight controls and standard operating procedures to ensure patients waiting for healthcare services receive them as soon as possible.

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<sup>8</sup> VHA memo, “Policy Update for Using and Maintaining Veterans Health Administration (VHA) Electronic Wait List (EWL) (VIEWS# 01370554),” August 6, 2019.

<sup>9</sup> VHA memo, “Simplification of New Patient Scheduling and Elimination of the Veterans Health Administration (VHA) Electronic Wait List (EWL) (VIEWS# 02953355),” June 18, 2020.

<sup>10</sup> VHA’s Consult Toolbox allows users to understand the overall status of consult management and identify specific services needing attention or resources.

## What the OIG Recommended

The OIG made three recommendations to the under secretary for health to improve the monitoring and oversight of patients waiting for healthcare services. The recommendations include developing and implementing clearly defined oversight controls and standard operating procedures to monitor and routinely review patients waiting to be scheduled for care. The OIG also recommended facility leaders clearly define and oversee procedures on how to routinely review and monitor transfer entries that had been moved to LEAF.

## Management Comments

The executive in charge, Office of the Under Secretary for Health, concurred with the recommendations and provided corrective action plans that are responsive to the intent of the recommendations. Appendix C includes the full text of the executive in charge's comments. The OIG will monitor the implementation of planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified.



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## Abbreviations

LEAF	Light Electronic Administrative Framework
OIG	Office of Inspector General
OMI	Office of the Medical Inspector
OVAC	Office of Veterans Access to Care
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

In May 2019, a Veterans Health Administration (VHA) employee alerted the media and the VA Office of Inspector General (OIG) to allegations that VHA was not accurately reporting its wait list data on its public website. The OIG conducted this audit to address those allegations and to also determine whether VHA managed the wait list in accordance with scheduling requirements for veterans' care, and whether VA medical facilities complied with wait list management policies.

The audit team addressed the allegations in finding 1 of this report. VA's Office of the Medical Inspector (OMI) also reviewed the allegations and provided recommendations to VHA, which are described in finding 1 as well. In addition to reviewing the specific allegations, this audit assessed VHA and its facilities' management of the wait list entries overall.

### Electronic Wait List

The wait list was developed in 2002 to help VA facilities manage veterans' access to outpatient health care and help clinics identify patients who need appointments. VA facilities use the wait list to record, track, and provide reports on patients who are unable to obtain timely appointments at particular VA medical facilities to ensure all patients who need care receive it as soon as possible. The wait list is VHA's official tool to manage requests for new patient appointments and for established patients with new problems that could not be scheduled within 90 calendar days of the date deemed clinically appropriate. Facilities are not permitted to maintain wait lists in other formats, including spreadsheets, paper lists, shared drives, calendars, or logbooks.

All VA facility wait lists are aggregated in a data report maintained in VHA's Support Service Center and accessible to VHA employees. The wait list report allows users to view wait list data by individual facility and service line, such as cardiology. The facility wait lists used to generate the aggregate data include entries for clinical services, such as new patients waiting for a primary or specialty care appointment. Wait lists also included entries that were administrative in nature, such as transfer requests by patients already receiving care at one VA facility to be seen at another, until a policy change in July 2019.

In 2014, VA began posting data about wait list entries and wait times on a public website as required by law.<sup>11</sup> Among the data posted was the total number of entries on the wait list.<sup>12</sup> The total wait list figure posted on the public website did not include administrative wait list entries.

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<sup>11</sup> Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 Stat. 1780, § 206 (2014).

<sup>12</sup> The publicly reported data also included figures such as scheduled appointments, appointments scheduled within 30 days, appointments scheduled more than 30 days away, and average wait times for appointments.

## Roles and Responsibilities

Since 2014, VHA's Office of Veterans Access to Care (OVAC) has been the primary national program office responsible for overseeing and directing VA's efforts to provide access to care, including the wait list, VHA's assistant deputy under secretary for health for clinical operations told the audit team. According to VHA Directive 1230 regarding outpatient scheduling, VA medical facility directors are responsible for appropriately managing the wait list, community care referrals, and clinic access, monitoring compliance with the directive, and reporting noncompliance to the Veterans Integrated Service Network (VISN) director.<sup>13</sup> Monitoring includes assessing the quality of performance over time and evaluating the results.<sup>14</sup> Both VISN and VA medical facility directors are responsible for ensuring veterans receive high-quality health care in a timely manner.

VHA Directive 1230 holds VA medical facility employees responsible for adding patients to the local wait lists as needed and routinely monitoring the lists to make certain those patients get appointments when needed. Employees are required to monitor wait list entries daily and remove patients after an appointment is made, when employees are unable to contact a patient, if the patient no longer needed the care, or if the patient is deceased. Scheduling patients from the wait list is determined by highest priority. Patient priority is determined largely by service-connected disabilities.<sup>15</sup> Further, supervisors and managers need to ensure that their local wait list is validated on a weekly basis, meaning it is accurately represented in the aggregated wait list in VHA's web-based tracking database, the VHA Support Service Center.

## Electronic Wait List Allegations

In September 2018, a VHA employee reported to OVAC leaders that VHA was not accurately reporting its wait list data on its public website. Specifically, the employee alleged a discrepancy in wait list figures reported on VA's public website versus what was included in internal data reports. The employee indicated that the discrepancy was the result of the exclusion of wait list entries older than 24 months from public reporting and that three stop codes were excluded from public reporting.<sup>16</sup> In an email to OVAC leaders, the employee wrote:

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<sup>13</sup> VHA Directive 1230(1), *Outpatient Scheduling Processes and Procedures*, July 15, 2016. Amended on July 12, 2019.

<sup>14</sup> GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

<sup>15</sup> A service-connected disability is an injury or illness that was incurred or aggravated during active military service. According to VHA Directive 1230(1), priority scheduling of any service-connected patient will not affect the medical care of any previously scheduled patient. However, urgent healthcare needs take precedence over a service-connected priority status.

<sup>16</sup> VHA documents say stop codes are used to define the type of clinical work or services provided, and for utilization tracking, comparing clinical programs, and performance measures, among other purposes. The three stop codes that were excluded were used to identify administrative entries such as community care consults (referrals), patient transfer requests, and employee occupational health needs.

The National EWL [electronic wait list] report shows 38,663 Veterans. Publicly we have only been reporting approximately 19,000. This discrepancy comes from EWL entries >24 months being exclude[d] from public reporting. Most of these are either admin or community care, but not all.... It could be seen as VA hiding a very large wait list of Veterans waiting extremely long for care.... we purposely excluded 3 stop codes and any entries >24 months.... I also do not understand why we exclude anything >24 months which is where we have EWL entries from various clinical stop codes.

In May 2019, the VHA employee reported allegations to the media and the VA OIG that VHA was not accurately reporting its wait list data on a public VA website. The OIG initiated this audit in part to address those allegations.

In March 2019, the office of the under secretary for health tasked OMI to review the wait list allegations. VHA released a report to the House Veterans' Affairs Committee and the Senate Veterans' Affairs Committee in June 2019. The report stated the review did not substantiate allegations that OVAC leaders covered up a secret wait list, or that the whistleblower's chain of command was not responsive to his claims.

However, OMI's review found that VHA's publicly reported data differed from VHA's internal data reports due to administrative stop codes being excluded from the publicly reported data reports. OMI's review also found that the wait list excluded entries older than 24 months but in September 2018, these entries were reviewed and scheduled at a facility or in the community if the patient still required care.

OMI recommended in its June 2019 report that VHA reevaluate wait list data to determine what stop codes should be included in the publicly reported data. OMI also recommended that OVAC ensure clinical entries are included on the wait list regardless of the length of time they have been there, continue to publicly report the wait list, and monitor and track the wait list to ensure patients are receiving timely access to care.

## **New Electronic Wait List Procedures in 2019**

VHA issued new guidance in July and August 2019 to VISNs and VA medical facilities that provided key changes to wait list procedures and initiated a significant review of facilities' wait lists. On July 8, 2019, the acting deputy under secretary for health for operations and management issued a memo to VISN directors that communicated key changes to wait list procedures. The memo, titled "MISSION Act Electronic Wait List Initiative and Key Electronic Wait List (EWL) Process Changes (VIEWS# 01338979)," required facility employees to review all wait list entries to identify whether patients were eligible for community care, VA appointment availability, and veteran preference for care. The memo also required facility employees to review and remove administrative entries from the wait list. For administrative

transfer entries, VHA employees were to contact veterans and offer a choice to receive care in the community if eligible or continue care at their current location.

On August 6, 2019, the acting deputy under secretary for health for operations and management issued another memo, “Policy Update for Using and Maintaining Veterans Health Administration (VHA) Electronic Wait List (EWL) (VIEWS# 01370554),” that required facilities to remove transfer requests from the wait list and place them on another VHA system, the Light Electronic Administrative Framework (LEAF) tool, for tracking purposes. LEAF replaced the use of the administrative wait lists for transfers and allows for the assignment of veterans seeking to transfer care within a healthcare system.

## Results and Recommendations

### **Finding 1: VA’s Wait List Figures on Its Public Website Did Not Include Entries Older Than Two Years or Administrative Entries**

The OIG substantiated that entries older than 24 months had not been included on the wait list as required, and that there was a discrepancy in wait list figures reported on VA’s public website versus what was included in internal data reports. These issues were also identified by VA’s OMI, which made recommendations to VHA to address these issues. VHA began including entries older than 24 months in October 2018 and developed new procedures to manage administrative wait list entries in July and August 2019.

#### **What the OIG Did**

To assess the merits of the allegations, the audit team reviewed data and emails provided by the VHA employee who made them, and independently obtained and analyzed wait list data from VHA’s web-based tracking database.

#### **VHA Had Entries Older Than 24 Months That Were Not Included on the Wait List**

Between the time VA began publicly reporting wait list data in 2014 through September 2018, the data did not include entries that were older than 24 months. According to OVAC’s national director of field support, a VHA Support Service Center access team supervisor, and OMI’s investigation, VHA applied a filter to the wait list data that excluded entries older than 24 months from both the internal and publicly reported wait list numbers. Therefore, the audit team concluded that anyone monitoring the wait list using these sources did not see administrative and clinical entries that were older than 24 months. On October 2, 2018, a VHA Support Service Center supervisor determined that there were about 22,400 wait list records older than 24 months. Of those, the audit team determined most were from administrative entries (noncount stop codes). However, just over 500 were from clinical stop codes that should have been included in the public wait list. Excluding entries older than 24 months from the wait list hindered VHA’s oversight of those entries and their ability to make certain those patients were identified and served—the wait list’s primary function.

OVAC’s national director of field support said the decision to exclude entries older than 24 months was made before she took over and she was unaware of why the entries were excluded. However, the executive director of OVAC’s access and clinic administration program was aware of the filter and explained that it was implemented because entries older than 24 months were assumed to be false positives—entries that had been addressed clinically, but never removed from the wait list. According to OVAC’s national director of field support, OVAC worked with

VA facility employees to review clinical and administrative wait list entries that were older than 24 months. This occurred after the VHA employee reported to OVAC leaders that VHA was not accurately reporting its wait list data on its public website but before the filter was removed. OVAC required the facilities to determine if the patients had received care or were transferred to their preferred facility, and, if so, the facilities were to remove the entries from the wait list. A VHA Support Service Center supervisor stated they removed the data filter to include entries older than 24 months around October 2018.

## **Internal Wait List Data Were Different Than the Public Wait List Data**

The audit team confirmed that there was a difference between the wait list figures reported on VA's public website versus what was included in internal data reports. The discrepancy occurred because VA's publicly reported wait list figures included entries for patients waiting for clinical care, such as primary care, mental health care, and specialty care services, but did not contain what VA considers administrative entries also known as noncount clinic entries. VHA policy indicates that the administrative entries in the noncount clinics were to be used for patients requesting transfers to other VA facilities or awaiting non-VA care.<sup>17</sup> Administrative entries include community care consults, also known as referrals, patient transfer requests, and employee occupational health needs.

The law requires VA to publish wait times for scheduling appointments for hospital care and medical services but does not distinguish between administrative and clinical wait times and wait list entries.<sup>18</sup> The law does not specifically require administrative entries to be reported. VHA policy said VHA facility employees are to use the wait list to also track administrative entries, but noted "they are not official wait lists" subject to the rules of clinic wait list entries.<sup>19</sup> VA's assistant deputy under secretary for health for clinical operations testified in July 2019 that VA made the decision to track administrative requests using the wait list software after 2014 but did not report these figures publicly because they were requests from veterans who were already receiving care.<sup>20</sup>

VHA acknowledged, and the audit team's analysis confirmed, that the public wait list data did not include administrative entries. The public VHA access data showed more than 11,800 entries on the wait list on June 1, 2019. In comparison, VHA's internal wait list data showed more than 37,600 total entries on that date. The following figures depict the difference in data reported

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<sup>17</sup> VHA Directive 1230(1).

<sup>18</sup> Veterans Access, Choice, and Accountability Act of 2014.

<sup>19</sup> VHA Directive 1230(1).

<sup>20</sup> *Hearing on True Transparency? Assessing Wait Times Five Years After Phoenix*, Department of Veterans Affairs, House Committee on Veterans' Affairs, 116 Cong. (July 24, 2019) (statement of Dr. Teresa Boyd, Assistant Deputy Under Secretary for Health for Clinical Operations, Veterans Health Administration).

publicly compared to what was included on VA’s internal wait list data reports through June 1, 2019.

Grand Total	1.Total Appts Scheduled	2.Appts Scheduled 30 Days or Under	3.Percent Appts Scheduled 30 Days or Under	4.Appts Scheduled Over 30 Days	5.Percent Appts Scheduled Over 30 Days	6. New Enroll Appt Req	7.EWL Count
National: 6/1/2019	11,203,827	10,434,248	93.13%	769,579	6.87%	7,863	11,834
National: 5/15/2019	10,886,574	10,141,879	93.16%	744,695	6.84%	3,388	12,028
National: 5/1/2019	10,961,193	10,220,027	93.24%	741,166	6.76%	3,769	12,003
National: 4/15/2019	10,972,866	10,230,227	93.23%	742,639	6.77%	3,308	11,836
National: 4/1/2019	10,921,147	10,177,852	93.19%	743,295	6.81%	3,300	11,874

**Figure 1.** Public VHA access data indicates more than 11,800 wait list entries, on June 1, 2019.

Source: VHA’s public website <https://www.va.gov/health/access-audit.asp>.

			EWL Records
06/01/2019	+ All Facility District	+ All Others	32,751
		+ Mental Health	1,528
		+ Primary Care	1,543
		+ Specialty Care	1,782

**Figure 2.** Internal VHA Support Service Center wait list data showed more than 37,600 total entries on June 1, 2019.

Source: VHA’s Support Service Center internal data.

Note: The category, “All Others” included administrative entries along with other clinical entries for various specialty care services.

## OMI Review of Wait List Allegations

These issues were also identified by OMI, following a request for review of the allegations by the under secretary for health in March 2019. In June 2019, VHA released its report to the House Committee on Veterans’ Affairs and the Senate Committee on Veterans’ Affairs. OMI’s review found that VHA’s publicly reported data differed from internal data reports due to administrative stop codes being excluded from the public reports. OMI recommended that VHA reevaluate wait list data to determine what stop codes should be included in the publicly reported data. OMI also recommended OVAC ensures clinical entries are included on the wait list regardless of the length of time, continues to publicly report the wait list, and reviews the wait list to ensure patients are receiving timely access to care.

## **Finding 1 Conclusion**

The OIG substantiated the allegations that entries older than 24 months had not been included on the internal and public wait lists, which hindered VHA personnel's oversight of those entries and their ability to ensure veterans awaiting healthcare services were identified and served as soon as possible, which is the fundamental purpose of the wait list. The audit team also found there was a discrepancy between the wait list figures reported on VA's public website versus what was included in internal data reports. However, federal law does not distinguish between administrative and clinical wait times and wait list entries. The audit team determined that VHA removed the 24-month filter, stopped using the wait list to manage administrative entries, and developed new procedures addressing wait list entries and therefore did not make recommendations specific to this finding.

## **Finding 2: VA Medical Facility Wait List Entries Were Not Reviewed and Validated as Required**

The OIG found patients were not removed from the wait list when appropriate, indicating employees did not review entries daily and supervisors did not validate the list weekly, thereby ensuring entries were accurately represented in VHA's web-based tracking database—the VHA Support Service Center. Of the nearly 11,800 clinical entries on the wait list, the audit team determined an estimated 2,400 entries remained on the list an estimated average of 277 days after they should have been removed. Significantly, the audit team identified 14 patients included in the team's sample of 120 clinical entries who had not received the care for which they were placed on the wait list. By January 31, 2020, those 14 patients had been on the wait list for an appointment or service for an average of 545 days.

In 2019, VHA made key changes to wait list procedures and initiated a significant review of facility lists. By April 2020, there were about 3,000 fewer clinical entries on the wait list than before the VHA initiative. Further, facilities began using the LEAF tool to track administrative entries.

Based on the audit team's review of VHA's wait list entries through June 1, 2019, the team concluded that neither OVAC nor facility leaders consistently monitored the wait list to ensure facilities were routinely reviewing it as required by VHA Directive 1230. This insufficient oversight created a risk that patients will not receive care in a timely manner. It also risks patients being overlooked for appointments or transfers to receive care at their preferred facility. Inadequate monitoring also could lead to excess entries on the wait list that make it appear veterans are experiencing longer delays in receiving care than is actually the case. Although VHA has made changes to advance its wait list management, the OIG has made three recommendations for further improvements.

### **What the OIG Did**

The audit team reviewed a statistical sample of 120 clinical wait list entries through June 1, 2019, to assess whether OVAC and facility leaders were properly managing the list as required by VHA policies. From November 2019 through April 2020, the audit team interviewed and communicated with leaders and employees from OVAC, VHA's Office of Communications, VHA's Support Service Center, and numerous VISNs and facilities. This finding discusses

- how VHA and its facilities managed clinical and administrative wait list entries,
- VHA's initiative to review all wait list entries, and
- the status of the VHA wait list and new processes for monitoring clinical and administrative wait list entries.

## Some VA Facilities Had a Significant Number of Administrative Entries on The Wait List

There were 25,770 administrative entries on the wait list on June 1, 2019. Nearly all these, 25,629, or 99 percent, were made to record which patients were waiting to be transferred from one VA facility to another within the same service area. The remaining instances of administrative entries were for (1) patients waiting to be seen at a community care facility (127 total entries) and (2) occupational health entries, typically used for VA employee health needs (14 total entries).

According to its national scheduling program manager, OVAC broadly monitored data for the clinical wait list entries but was not as concerned about monitoring administrative entries because OVAC officials assumed such patients were already receiving care. These transfer administrative entries are depicted in table 1.

**Table 1. Facilities with the Most Significant Number of Administrative Transfer Requests on the Wait List (on June 1, 2019)**

Facility	Administrative transfer request entries (rounded)
South Texas Veterans Health Care System (San Antonio)	11,800
James A. Haley Veterans' Hospital (Tampa, Florida)	2,700
VA Portland Health Care System (Oregon)	2,800
Atlanta VA Health Care System	1,900

*Source: OIG analysis of VHA's wait list data obtained from VHA's Support Service Center.*

*Note: All other facilities had less than 1,000 of these entries and so have been excluded from this table.*

According to VHA policy, patients waiting for a transfer remain assigned to their current facility and provider until the requested facility has the capacity to accept them. At that point, employees will schedule an appointment and remove the transfer wait list entry.<sup>21</sup>

## South Texas Veterans Health Care System Accounted for Almost Half the Transfer Wait List Entries

Facilities within the South Texas Veterans Health Care System accounted for almost half the transfer request entries on the wait list. OVAC leaders stated that they were aware of the high

<sup>21</sup> VHA Directive 1230(1).

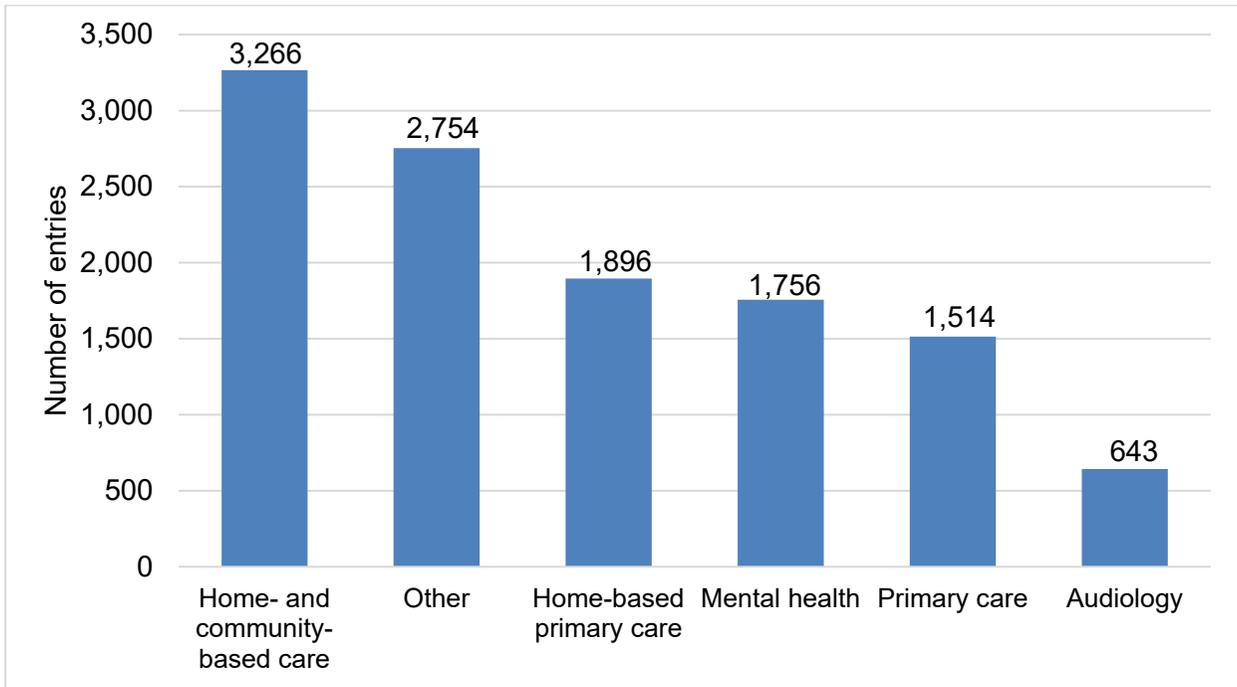
number of entries originating from the South Texas Veterans Health Care System. The administrative officer for primary care at this healthcare system said managing the transfer entries had not been a priority because those patients were presumably receiving care with their assigned providers while they awaited transfers to their requested facility.

The OIG found that some entries on the wait list had been there since 2015 and 2016. This indicated that the wait list was not being reviewed and validated, which puts patients at risk of being overlooked for an opportunity to transfer to a specific facility. The audit team reviewed 10 transfer entries included in the South Texas Veterans Health Care System's wait list and found five patients were receiving care at a VA medical facility or in the community while waiting to be transferred to another facility. The other five patients should have been removed from the wait list because they either received the requested transfer or the facilities were unable to contact the patient.

### **VA Facilities Had More Than 11,800 Clinical Entries on the Wait List**

More than 11,800 entries on the wait list were categorized as patients waiting for clinical services. Of these, more than 3,200 entries (27 percent) were for home- and community-based services. These services are for patients who need skilled or unskilled services such as case management, help with activities of daily living, or health care in their home. The OIG found that while a patient may be found eligible for home- and community-based services, increasing demand and the lack of staffing, budget, and community resources can potentially delay or prevent intended services from being provided, resulting in placement on the wait list. Patients who require these services will remain on the wait list until they are seen.

The other clinical entries on the wait list were primarily for audiology, primary care, mental health, and home-based primary care. Home-based primary care is different than home- and community-based services. It refers to care provided to patients in their home and is used for patients who have complex healthcare needs and for whom routine clinic-based care is not effective. Also included were entries for gastrointestinal endoscopy or optometry, among other services. Figure 3 represents a breakdown of the top clinical entries by service through June 1, 2019.



**Figure 3.** Wait list entries on June 1, 2019.

Source: VA OIG analysis of clinical wait list entries.

Note: The category “other” combines all other services for which patients were waiting that were not already mentioned in figure 3, such as infectious diseases, gastrointestinal endoscopy, or optometry, among others. Each of these “other” services had fewer than 200 entries individually.

### **VA Facility Employees Did Not Effectively Manage Wait List Entries as Required**

Through June 1, 2019, VHA’s wait list included about 7,200 clinical entries that were older than 30 days. More than 3,000 of these entries (42 percent) were on the wait list since 2018 or earlier. Table 2 depicts all clinical entries through that date, and the year the entries were added to the wait list.

**Table 2. Clinical Entries on the Wait List by Year Entered (through June 1, 2019)**

Year the entry was placed on the wait list	Number of clinical entries
2010	1
2011	0
2012	1
2014	14
2015	62
2016	187
2017	458
2018	2,898
2019	8,207

*Source: OIG analysis of data obtained from VHA's Support Service Center on June 1, 2019.*

The audit team conducted a sample review of 120 entries identified on the June 2019 wait list and determined that an estimated 5,700 (80 percent) were removed by September 2019.<sup>22</sup> VHA policy requires that employees remove patients from the wait list after a qualifying action occurs, such as when employees have determined a patient received an appointment for VA care or care in the community, moved to another location serviced by another VA medical center, no longer needs care, or died.<sup>23</sup>

Of the estimated 5,700 entries removed, the audit team determined that about 2,400 (42 percent) should have been removed earlier. These entries remained on the wait list an estimated average 277 days after a qualifying action requiring removal occurred. Within the sample the audit team generally found that the patients should have been removed sooner because they had already received an appointment for the requested care or received the care in the community. VHA policy required facility employees to review wait list entries daily to offer open appointments to patients and remove patients when appropriate, and supervisors to validate the wait list weekly.<sup>24</sup> The OIG concluded this indicated that facility employees were not effectively monitoring and validating the wait list to remove patients on time. When employees do not remove patients from the list when appropriate, it creates the appearance that patients have been waiting longer than is actually the case for care or services.

<sup>22</sup> Figures and percentages have been rounded for reporting purposes; therefore, totals may not always sum.

<sup>23</sup> VHA Directive 1230(1).

<sup>24</sup> VHA Directive 1230(1).

### Example 1

*A patient was entered on the wait list for home-based primary care on April 19, 2018. The patient began receiving this care on June 21, 2018. However, the patient was not removed from the wait list until June 4, 2019—354 days after the patient should have been removed. A facility employee said schedulers failed to remove the patient on time due to human error.*

## Facilities Removed Patients as a Result of VHA’s Mandated Review in July 2019

The audit team determined that an estimated 3,100 of the 7,200 clinical entries were removed between July 8 and August 31, 2019, indicating that facility employees reviewed and removed the entries in response to VHA’s July 8, 2019, memo.<sup>25</sup> These patients were on the wait list for an estimated average of 294 days before they were removed. The audit team determined some of these entries should have been removed earlier because there had been a qualifying action.

### Example 2

*A patient was entered on the wait list on November 30, 2017, for a podiatry appointment. On January 17, 2018, the patient opted to receive care in the community. However, the patient remained on the wait list for 554 days after opting for community care. VA facility employees eventually removed the patient from the wait list on July 25, 2019. A facility employee stated that the entry should have been removed at the time the appointment was scheduled and acknowledged that if the wait list was being monitored, the patient would have been removed sooner. The employee also said staff responsible for the review of the wait list needed retraining.*

The audit team determined that 53 patients in the sample were removed from the wait list from July 8 through August 31, 2019, however, 25 should have been removed earlier because they had a qualifying action for removal.<sup>26</sup> The audit team determined facility employees contacted some of these patients to attempt to schedule them in response to the memo. Some of these patients received appointments once they were contacted by facility employees while others that employees were unable to reach received letters asking them to contact the VA regarding their care. Based on the audit team’s sample, VHA facility employees removed patients from the wait list that did not respond to VA within about 14 days.

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<sup>25</sup> VHA memo, “MISSION Act Electronic Wait List Initiative and Key Electronic Wait List (EWL) Process Changes (VIEWS# 01338979),” July 8, 2019.

<sup>26</sup> Results were not projected in this instance due to the low number of samples in this subpopulation.

Eight of these patients were on the wait list for audiology appointments at the Charles George VA Medical Center in Asheville, North Carolina. The audit team determined facility employees offered the patients care in the community, but the patients opted for VA care and to be placed on the wait list. However, facility employees did not contact those patients to schedule them until July 2019, during the time of the mandated review. The eight patients remained on the wait list for an average of 192 days, including one who was on the list for 359 days before being offered an appointment. Therefore, either there had been no capacity to schedule these patients until July 2019, or employees had not monitored the wait list to ensure those patients were offered appointments upon clinic availability.

### **Example 3**

*A patient was placed on the wait list on September 17, 2018, for an audiology appointment. A facility employee sent a letter to the patient on July 19, 2019, regarding scheduling an audiology appointment. The patient was removed from the wait list on July 31, 2019, after the patient did not respond to the letter. A facility employee stated that July 19, 2019, was the first time the patient was contacted about the appointment and claimed that there had been no significant changes in appointment availability before that date. Before the removal, the patient had been on the wait list for 317 days.*

The audit team also found some instances within the sample review in which employees entered patients on the wait list in error and did not remove the entries. This generally occurred when an employee inadvertently entered the patient on the wait list even though the employee had already scheduled, or the patient had already received, the requested appointment. On average, those erroneous entries remained on the wait list for an estimated average 263 days.

### **Example 4**

*A patient was placed on the wait list on January 31, 2018, for polytrauma care. According to the patient's medical records, the patient was to come back in one year, with no mention of the patient needing a polytrauma-related appointment. However, the patient was not removed until July 22, 2019—507 days after being placed on the wait list in error. An employee from the facility acknowledged employees would have noticed how long patients were on the wait list if it was being properly monitored.*

## **Some Patients on the Wait List Were Still Waiting for Requested Care or Service for Months or Years**

The audit team determined that 14 patients in its sample review had still not received the care for which they were placed on the wait list by January 31, 2020. Those 14 patients had been waiting for appointments or services for an average of 545 days.<sup>27</sup>

Of those patients, 12 patients from three different facilities were waiting for home- and community-based services. As mentioned previously, services may have been delayed due to limited program resources.

Two other patients were still waiting for individual mental health counseling—at the same facility. One of them was placed on the wait list in April 2019 for individual mental health counseling and elected to participate in group mental health counseling in the meantime. The other patient was added to the wait list for individual trauma-focused therapy in April 2019 after the patient opted not to receive care in the community. A facility employee said the reason the patients were waiting for care was because there were multiple mental health provider vacancies at the facility.

## **OVAC and VA Facility Employees Could Improve Monitoring of the Wait List**

Based on the team's sample review, facility employees did not consistently remove entries from the wait list when appointments and other qualifying actions for removal were made. One facility group practice manager acknowledged employees needed to do a better job at monitoring to ensure entries were not on the wait list after an appointment had been made. Supervisors also did not consistently validate data to determine if entries should have been removed. This resulted in entries remaining on the wait list for months and in some cases years longer than necessary. Facilities in the sample did not have local standard operating procedures specifically for monitoring and validating their wait lists. When the audit team asked facility employees to describe processes for validating the wait list, most were not able to articulate what was required. One acting group practice manager expressed that the facility does not have a standardized process that explained how to validate the wait list weekly as required. She said she has set up a dashboard to track the wait list and is also reviewing consults every 30 days to ensure the entries are not on the wait list for a long time.

OVAC personnel said they only reviewed the total number of entries on the wait list and checked whether the entries were increasing or decreasing, because it was the responsibility of the facilities and VISNs to ensure compliance with VHA wait list requirements. Therefore, OVAC identified positive and negative wait list trends. However, the audit team concluded that by only

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<sup>27</sup> Results were not projected in this instance due to the low number of samples in this subpopulation.

looking at trends, OVAC would not have known facilities were not completing reviews and validations.

If patients remain on the wait list after they received appointments or no longer need the care, VHA and facility leaders will not have an accurate understanding of how many veterans are waiting—and how long—for care. Therefore, if OVAC routinely reviewed facilities and VISNs' control activities, it could better oversee access to care and address risks related to the wait list.

Recommendations 1 and 2 address the need for VHA to develop and implement oversight controls and monitor the patient care requests that are identified as “unable to schedule” and to ensure standard operating procedures are implemented so that employees routinely review and act on these patient care requests. These recommendations will assist VHA in ensuring patients are scheduled for care in a timely manner.

### **VHA Initiated a Review of All Wait List Entries in July 2019**

On July 8, 2019, the acting deputy under secretary for health for operations and management issued a memo to VISN directors that communicated key changes to wait list procedures. The memo, titled “MISSION Act Electronic Wait List Initiative and Key Electronic Wait List (EWL) Process Changes (VIEWS# 01338979),” included the following:

- The wait list would no longer be used for administrative purposes.
- New patient appointments may be scheduled up to 390 days into the future, instead of the former limit of 90 days.<sup>28</sup>

Facility employees were also required to review all wait list entries to identify whether patients were eligible for community care, VA appointment availability, and veteran preference for care. The memo required facility employees to review and remove administrative entries from the wait list. For administrative entries, employees were to contact veterans and offer a choice to receive care in the community, if eligible, or continue care at their current location.

This memo required facility leaders to review their wait list entries by July 19, 2019, and act as necessary. According to the attestations signed by facility directors nationwide, 84 facilities (60 percent) complied with the wait list review by July 19, 2019. By September 18, 2019, all facility directors had attested that they reviewed and acted on their wait list entries as required.

On August 6, 2019, the acting deputy under secretary for health for operations and management issued another memo, titled “Policy Update for Using and Maintaining Veterans Health Administration (VHA) Electronic Wait List (EWL) (VIEWS# 01370554),” requiring facilities to

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<sup>28</sup> This simply means that appointments may technically be scheduled beyond 90 days into the future and there is no longer a requirement to place new patients waiting more than 90 days for an appointment on the clinical wait list. However, facilities are still required to follow VHA Directive 1230 that sets a goal of scheduling appointments no more than 30 calendar days from the date an appointment is deemed clinically appropriate.

move transfer requests from the wait list to the LEAF system. OVAC's field support employees said OVAC ensured facilities were reducing the number of entries on the wait list by reviewing the total number of entries on the wait list week-to-week but did not conduct a detailed review of the entries removed.

### **Review of Administrative Wait List Entries at the South Texas Veterans Health Care System Identified Patients Who No Longer Had Primary Care Providers**

As previously stated, facilities in the South Texas Veterans Health Care System accounted for almost half—about 11,800—of the administrative wait list entries. The healthcare system's deputy chief of staff told the audit team there was a concern about removing the significant number of entries they had and creating another wait list without further guidance.

On August 6, 2019, VHA issued updated guidance that stated administrative entries are to be transferred to the LEAF for tracking. OVAC's national director of field support granted the South Texas Veterans Health Care System an extension until September 2019 to comply with the requirement to review and remove administrative entries from the wait list. Employees then moved their approximately 11,800 administrative entries to LEAF before contacting each patient. The South Texas Veterans Health Care System's director certified the facility had complied with the memo in September 2019. However, according to employees responsible for performing this work, they did not begin contacting those patients until January 2020, about six months later than required.

Although OVAC and facility employees stated they were not as concerned with administrative entries because they assumed such patients were already receiving VA care, South Texas Veterans Health Care System employees identified during their review almost 800 entries that did not have an assigned VA primary care provider. According to the primary care administrative officer, this can occur if the patient did not have a primary care appointment within the prior 24 months at the assigned medical center.

According to South Texas Veterans Health Care System's primary care administrative officer, employees attempted to contact patients to determine whether they still wanted to be transferred, had moved, or were being seen in the community. By reviewing patient records and calling patients, employees determined that about 260 (32 percent) of the almost 800 patients without assigned VA primary care providers had either received care outside of VA or had moved and were receiving care in a different healthcare system. About 50 other patients' records showed evidence of VA referrals for care in the community. Facility employees were not able to contact the remaining patients and therefore could not determine if the patients were receiving care. Facility employees later mailed letters to those patients to provide information on receiving VA care and enrollment.

The audit team concluded that failure to monitor the administrative wait list meant patients were not given an opportunity to transfer their care to their desired facility and created a risk that patients without a primary care provider assigned were no longer receiving care in the VA healthcare system. If the wait list entries had been reviewed and validated, South Texas Veterans Health Care System leaders and employees could have made earlier efforts to reach out to those patients. Employees might have determined if patients were receiving care in the community or if those patients still wanted or needed VA care.

## Current Status of the Wait List

VHA's guidance to VA medical facilities in July and August 2019 provided key changes to wait list procedures and initiated a significant review of facilities' wait lists. Further, on January 22, 2020, VHA amended Directive 1230 to include additional requirements for reporting administrative entries.<sup>29</sup> Specifically, the directive says, "Medical centers who elect to administratively track Veterans receiving VA care who request transfer to another VA facility or provider must utilize the Light Electronic Administrative Framework (LEAF) tool."

In April 2020, there were about 9,000 clinical wait list entries, about 3,000 less than before the VHA initiatives in 2019, and seven administrative entries on the wait list. It is important to note that VHA's data from January 1, 2020, through May 13, 2020, did not indicate a significant increase or decrease in wait list entries due to the COVID-19 pandemic. VHA provided guidance during March 2020 that stated "the [Electronic Wait List] is not to be used as a holder for consults or appointments waiting to be rescheduled" due to the coronavirus.<sup>30</sup> The guidance indicated that facilities will use a report in VHA's Support Service Center database to track appointments canceled related to COVID-19.

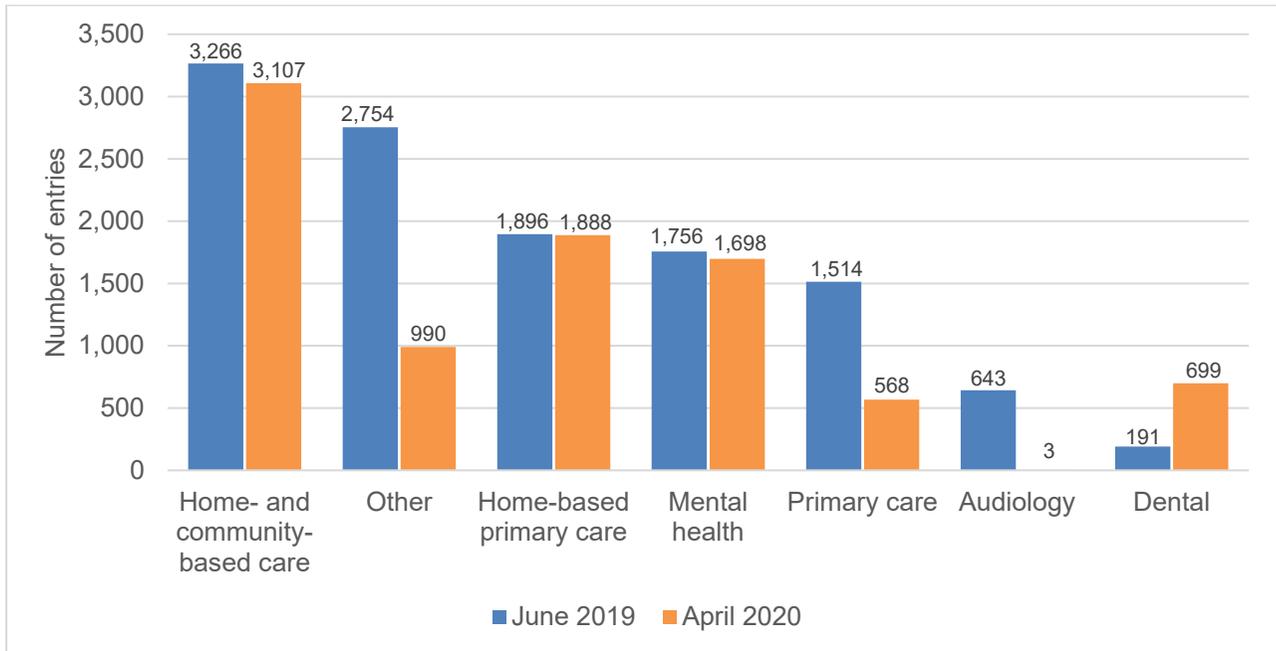
The approximately 9,000 entries had been on the wait list for an average of 142 days by April 2020, and more than 3,800 entries were on the wait list for more than 90 days. The nearly 9,000 wait list entries included more than 3,100 entries for home- and community-based care. OVAC's national director of field support said home- and community-based care is in high demand, which is why patients are on the wait list for longer periods for this service. The other top entries were home-based primary care, mental health, dental, and primary care.

Figure 4 represents a breakdown of the top clinical entries by service in April 2020 compared to the number of clinical entries from June 2019.

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<sup>29</sup> VHA Directive 1230(2) Outpatient Scheduling Processes and Procedures, July 15, 2016. Amended on January 22, 2020.

<sup>30</sup> VHA Memo, "Outpatient Clinic Appointment Scheduling Management in Response to COVID-19 Pandemic," March 22, 2020.



**Figure 4.** Comparison of top wait list entries.

Source: VA OIG analysis of clinical wait list entries from June 2019 and April 2020.

Note: The category “other” combines all other services for which patients were waiting that were not already mentioned in figure 4, such as gastrointestinal endoscopy, optometry, and others.

In June 2020, the assistant under secretary for health for operations issued a memo to VISN directors explaining that VHA plans to eliminate the use of the electronic wait list “in an effort to simplify and expedite scheduling of new patients.”<sup>31</sup> According to the memo, by December 1, 2020, all clinical entries on the wait list should be reviewed and scheduled or dispositioned if care has been rendered or is no longer needed. Further, VHA plans to use its consult toolbox to identify and track new patients that cannot be scheduled in a timely manner, and no longer use the electronic wait list. VHA’s consult toolbox allows users to understand the overall status of consult management and identify specific services needing attention or resources.

As VHA moves to eliminate the use of the wait list it is imperative to have strong oversight controls and standard operating procedures to ensure patients waiting for healthcare services receive it in a timely manner, as stated in recommendations 1 and 2 of this report.

<sup>31</sup> VHA memo, “Simplification of New Patient Scheduling and Elimination of the Veterans Health Administration (VHA) Electronic Wait List (EWL) (VIEWS# 02953355),” June 18, 2020.

## Current Status of Administrative Entries

According to July 2020 data provided by OVAC, 21 facilities were using LEAF and had a combined total of over 7,700 entries. According to OVAC employees, the other facilities that were not using LEAF did not have administrative transfer entries.

In January 2020, the South Texas Veterans Health Care System administrative officer for primary care stated that no internal policy or procedures for LEAF had been created. By March 2020, that system had established oversight responsibilities for primary care and medical administration services such as reporting on the status of entries in LEAF, which required these services to completely review the transfer wait list once a year and call patients to identify whether they would like to remain on the list.

The audit team noted that the updated January 2020 scheduling directive did not address who is responsible for implementing processes and procedures for monitoring and assessing the quality of LEAF's performance. According to OVAC's national director of field support, there is no policy oversight of LEAF. Without effective monitoring procedures and oversight of LEAF entries, VA medical facilities are at risk of re-accumulating a significant number of unaddressed transfer requests.

Recommendation 3 addresses the need for facility leaders to clearly define and oversee procedures on routinely reviewing, monitoring, and addressing the transfer entries in LEAF.

## Finding 2 Conclusion

The OIG found VA facilities were not properly removing entries from the wait list in accordance with VHA policy.<sup>32</sup> Failure to properly address and remove entries from the wait list gives VHA and facility leaders an inaccurate picture of how many patients are waiting long periods for care. Facility employees did not consistently monitor the wait list and lacked a clear understanding of how to routinely validate wait list entries. Proper oversight would ensure veterans waiting for appointments would be more easily identified and served.

The audit team determined that an estimated 3,100 entries were removed between July 8 and August 31, 2019, indicating that facility employees reviewed and removed the entries in response to VHA's July 8, 2019, memo. Some of these patients received appointments during this time, while others who did not respond to employees attempts to contact them were removed from the wait list. Within the sample, there were eight patients on the wait list for audiology appointments that facility employees did not contact to schedule until July 2019. Those eight patients were removed after an average of 192 days on the wait list. The OIG concluded that either there had been no capacity to schedule these patients until July 2019 or staff had not

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<sup>32</sup> VHA Directive 1230(1).

monitored the wait list to make certain that patients were scheduled as appointments became available.

VHA required facilities to remove transfer requests from the wait list and place them on the LEAF tool for tracking purposes. Effective and regular review and monitoring of the wait list is critical to ensure patients receive care in a timely manner and are not overlooked if they need a transfer to a specific facility. In addition, effective oversight would mitigate the risk of accumulating excessive entries that make it appear that veterans were waiting longer than is actually the case to receive healthcare services.

### **Recommendations 1–3**

The OIG recommended the under secretary for health<sup>33</sup>

1. Has oversight controls developed and implemented to monitor all facilities' patient care requests that are identified as "unable to schedule" to ensure patients across the Veterans Health Administration are scheduled in a timely manner;
2. Ensures standard operating procedures are being implemented so that facility employees routinely review and act on patient care requests identified as "unable to schedule" in the consult toolbox; and
3. Makes certain facility leaders clearly define and oversee procedures on routinely reviewing, monitoring, and addressing transfer entries on the Light Electronic Administrative Framework.

### **Management Comments**

The executive in charge, Office of the Under Secretary for Health, concurred with recommendations 1 through 3 of the report. To address recommendation 1, the executive in charge reported VHA will implement oversight controls developed to monitor all medical center patient care requests that are identified as "unable to schedule." He said primary monitoring and oversight responsibilities will be managed at the medical center and VISN levels respectively, and that national program offices including OVAC will serve as a resource to support medical centers.

To address recommendation 2, the executive in charge reported OVAC and other national program offices will collaborate with VISNs to ensure implementation of standard operating procedures focused on using the consult toolbox. He further stated that medical centers, VISNs, program offices, and OVAC will monitor "unable to schedule" entries and ensure standard operating procedures are clear, in place, and followed.

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<sup>33</sup> Recommendations directed to the under secretary for health were submitted to the executive in charge who has the authority to perform the functions and duties of the under secretary.

To address recommendation 3, the executive in charge reported that guidance was included in the recent update to VHA's scheduling directive (published January 20, 2020) that requires medical centers use the LEAF tool if they elect to administratively track veterans receiving VA care who request transfer to another VA facility or provider. He said OVAC will follow up with facilities to ensure appropriate transfers from one site to another site of care.

## **OIG Response**

The executive in charge's corrective action plans are responsive to the intent of the recommendations. The OIG will monitor implementation of planned actions and will close the recommendations when VHA provides sufficient evidence demonstrating progress in addressing the intent of the recommendations and the issues identified. Appendix C includes the full text of the executive in charge's comments.

## Appendix A: Scope and Methodology

### Scope

The audit team conducted its work from November 2019 through July 2020. The scope of the audit focused on assessing allegations made by a VHA employee in September 2018 that there was a discrepancy in wait list figures reported on VA's public website versus what was included in internal data reports. In addition, the audit team assessed whether VA managed the wait list in accordance with VHA requirements by analyzing aggregate clinical and administrative wait list data, and by sampling 120 of about 11,800 clinical entries that were on the wait list on June 1, 2019, and older than 30 days (or older than 30 days beyond the patient's requested appointment date).

### Methodology

The audit team conducted virtual meetings with the VHA employee who made the allegations, and reviewed data and emails provided by the employee. The audit team also independently obtained June 1, 2019, wait list data from VHA's web-based tracking database. Included in the analysis of that wait list data was a statistical sample of entries from 10 VA medical facilities to assess whether a patient received the requested appointment and if the entry was removed from the wait list on time. The team used VHA's Compensation and Pension Record Interchange system to assess if VHA managed these clinical entries in accordance with Directive 1230.

The audit team conducted aggregate data analysis on about 37,600 clinical and administrative entries on the wait list as of June 1, 2019, to determine whether facilities and OVAC were monitoring the wait list before the July 2019 memo established the requirements.

The audit team conducted a site visit to the South Texas Veterans Health Care System in January 2020 and interviewed facility and VISN employees and leaders. The team also interviewed employees from OVAC, VA's Office of Communications, various VISNs, and VHA's Support Service Center to obtain information about the wait list. In addition, the audit team interviewed and communicated with the following facilities that were included in the review of wait list entries:

- Cincinnati VA Medical Center, Ohio
- VA Western Colorado Health Care System, Grand Junction
- Robert J. Dole VA Medical Center, Wichita, Kansas
- VA New York Harbor Health Care System
- VA Central Western Massachusetts Healthcare System, Leeds
- Charles George VA Medical Center, Asheville, North Carolina

- VA Sierra Nevada Health Care System, Reno
- Salem VA Medical Center, Salem, Virginia
- VA Puget Sound Health Care System, Seattle, Washington
- Mann-Grandstaff VA Medical Center, Spokane, Washington
- VA Long Beach Health Care System, California
- VA Portland Health Care System, Oregon
- Atlanta VA Health Care System, Decatur, Georgia

## Internal Controls

The audit team determined that internal controls were significant to the audit objective. The team assessed the internal controls of VHA applicable to the audit objective. This assessment of the five internal control components included control environment, risk assessment, control activities, information and communication, and monitoring. In addition, the team reviewed the principles of internal controls associated with the audit objective.<sup>34</sup> The team identified the following three components and related principles as significant to the audit objective and identified internal control weaknesses and proposed recommendations 1–3 in finding 2 to address oversight controls and operating procedures to monitor consults and administrative entries:

- Component 3: Control Activities, Principle 12—Management should implement control activities through policies.
- Component 4: Information and Communication, Principle 15—Communication with external parties and appropriate methods of communication.
- Component 5: Monitoring Activities, Principle 16—Establishment of a baseline, internal control system monitoring, and evaluate results.

## Fraud Assessment

The audit team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this audit. The team exercised due diligence in staying alert to any fraud by taking actions such as soliciting the OIG’s Office of Investigations for indicators and reviewing relevant OIG hotline complaints and concerns that might point to potentially fraudulent activity. The audit team did not identify any instances of fraud during this audit.

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<sup>34</sup> Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-70G, September 2014.

## **Data Reliability**

The audit team obtained computer-processed data from VHA's Support Service Center of total wait list entries on June 1, 2019. To assess the reliability of these data, the audit team performed testing by comparing wait list entry details from VHA Support Service Center data to individual patient records from the Compensation and Pension Record Interchange. The audit team also tested the completeness of the wait list found in VHA Support Service Center by comparing it to the total population found in VHA's Corporate Data Warehouse. Lastly, the team tested VHA's Support Service Center disposition data for fiscal year 2019. The team tested the VHA disposition details for reliability against individual patient records. The audit team concluded that the computer-processed data obtained from VHA Support Service Center were sufficiently reliable to support the audit objectives, conclusions, and recommendations.

## **Government Standards**

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the team plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on the audit objectives. The OIG believes that the evidence obtained provides a reasonable basis for its findings and conclusions based on the audit objectives.

## **Appendix B: Statistical Sampling Methodology**

To determine whether VA managed the wait list in accordance with requirements, the audit team analyzed a sample of clinical wait list entries that were older than 30 days by June 1, 2019. The OIG used statistical sampling to project the number of clinical entries that were reviewed and monitored in accordance with VHA requirements.

### **Population**

The population included over 37,600 entries for patients that were on the wait list on June 1, 2019. From this population, the audit team focused on aged clinical entries by excluding all administrative entries that were listed on the wait list, along with any entries 30 days old or less from the originating date of June 1, 2019. From there, the audit team identified a population of about 7,200 clinical entries.

### **Sampling Design**

The audit team used a cluster sampling approach. Ten primary facilities were selected as clusters using probability proportional to size where the size measurement was the number of records associated with each facility. Twelve records were then chosen from each of the primary facilities using simple random sampling. This sampling design was representative of the population and ensured projections describe the entire population. This sampling methodology resulted in the review of 120 clinical entries that were greater than 30 days from the originating date by June 1, 2019. The audit team reviewed the patients' electronic health records for each entry.

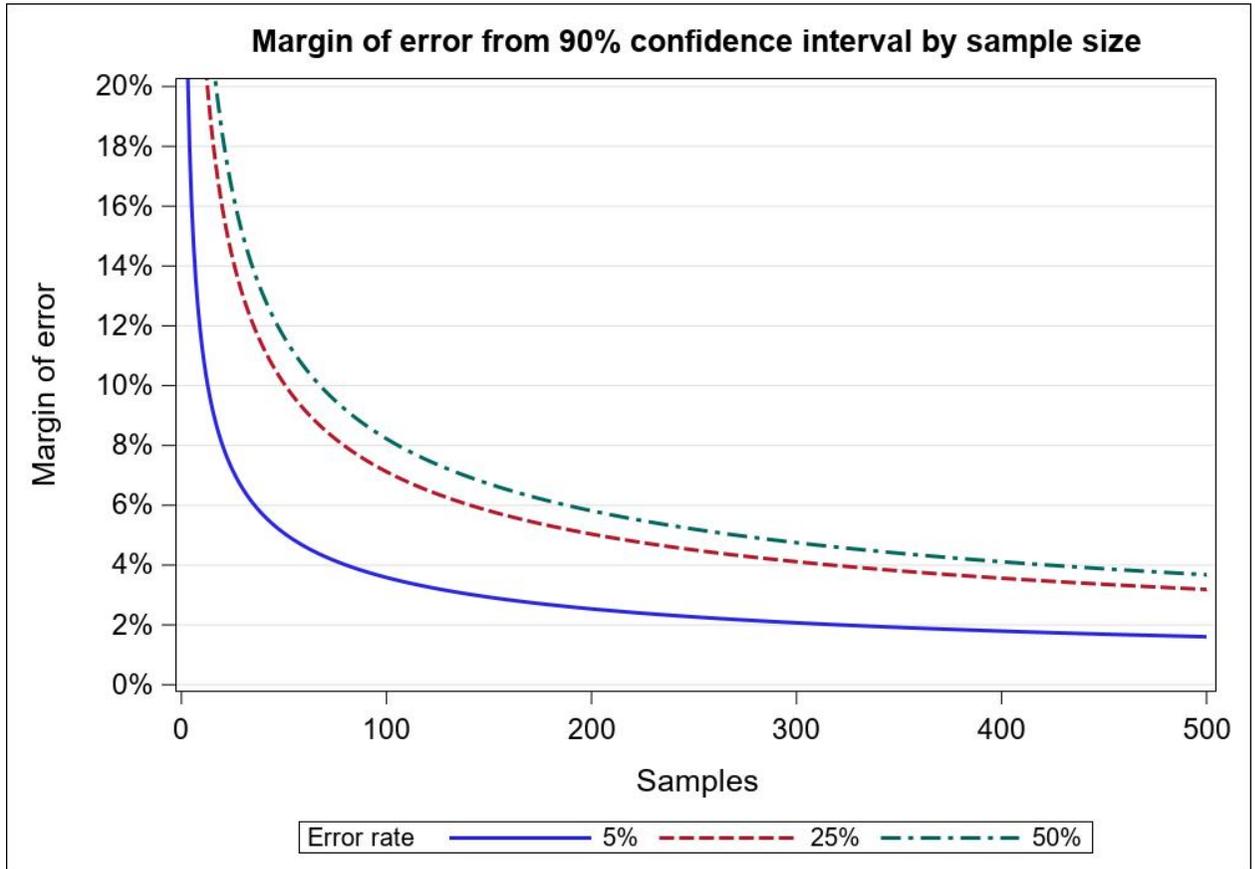
### **Projections and Margins of Error**

The point estimate (estimated error) is an estimate of the population parameter obtained by sampling. The margin of error and confidence interval associated with each point estimate is a measure of the precision of the point estimate that accounts for the sampling methodology used. If the OIG repeated this audit with multiple samples, the confidence intervals would differ for each sample but would include the true population value 90 percent of the time.

The OIG statistician employed statistical analysis software to calculate the weighted population estimates and associated sampling errors. This software uses replication methodology to calculate margins of error and confidence intervals that correctly account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistical concerns of sample review. While precision improves with larger samples, the rate of improvement does not significantly change as more records are added to the sample review.

Figure B.1 shows the effect of progressively larger sample sizes on the margin of error.



**Figure B.1.** The effect of progressively larger sample sizes on the margin of error.

Source: VA OIG statistician’s analysis.

The following tables present estimates from the sample results, including the estimate, margin of error, lower 90 percent value and upper 90 percent value.

Table B.1 details the audit projection for the breakdown by wait list entries that were removed but should have been removed earlier.

**Table B.1. Wait List Entries that Should Have Been Removed Earlier**

Entries that should have been removed earlier	Estimate	Margin of error	90% confidence interval lower limit	90% confidence interval upper limit	Count from sample
Yes	2,439	1,598	841	4,037	42
No	2,866	4,416	1,450	4,281	48
NA	423	541	7	964	7
<b>Total</b>	<b>5,728</b>	<b>1,037</b>	<b>4,692</b>	<b>6,765</b>	<b>97</b>

Source: VA OIG analysis of statistically sampled wait list entries on June 1, 2019.

Table B.2 details the audit projection for the estimated number of days patients remained on the wait list after a qualifying action occurred requiring the entry to be removed from the wait list.

**Table B.2. Average Number of Days Patients Remained on the Wait List After a Qualifying Action Occurred**

Category	Estimate	Margin of error	90% confidence interval lower limit	90% confidence interval upper limit	Count from sample
Days	277	52	225	329	42

Source: VA OIG analysis of statistically sampled wait list entries on June 1, 2019.

Table B.3 details the audit projection for the entries removed between July 8 and August 31, 2019, indicating that facility employees reviewed, and if required, removed the entries in response to OVAC’s July 8, 2019, memo.

**Table B.3. Wait List Entries Removed Between July 8 and August 31, 2019**

Entries removed between July 8 and August 31, 2019	Estimate	Margin of error	90% confidence interval lower limit	90% confidence interval upper limit	Count from sample
Yes	3,134	1,316	1,818	4,450	53
No	4,030	1,379	2,650	5,409	67
<b>Total</b>	<b>7,163</b>	<b>206</b>	<b>6,957</b>	<b>7,370</b>	<b>120</b>

Source: VA OIG analysis of statistically sampled wait list entries on June 1, 2019.

Table B.4 details the audit projection for the average number of days on the wait list for entries removed between July 8 and August 31, 2019.

**Table B.4. Average Number of Days on the Wait List for Entries That Were Removed between July 8 and August 31, 2019**

Category	Estimate	Margin of error	90% confidence interval lower limit	90% confidence interval upper limit	Count from sample
Days	294	44	250	338	53

Source: VA OIG analysis of statistically sampled wait list entries on June 1, 2019.

Table B.5 details the entries, and the correlating percentages, removed from the wait list by September 2019.

**Table B.5. Wait List Entries Removed by September 2019**

Category	Estimate	Margin of error	90% confidence interval lower limit	90% confidence interval upper limit	Count from sample
Yes	5,728 (80%)	1,037 (16%)	4,692 (64%)	6,765 (96%)	97
No	1,435 (20%)	1,187 (16%)	248 (4%)	2,622 (36%)	23

Source: VA OIG analysis of statistically sampled wait list entries on June 1, 2019.

Table B.6 details the average number days entries remained on the wait list after they were entered in error.

**Table B.6. Average Days on the Wait List for Entries that Were Entered in Error**

Category	Estimate	Margin of error	90% confidence interval lower limit	90% confidence interval upper limit	Count from sample
Yes	263	61	201	324	18

Source: VA OIG analysis of statistically sampled wait list entries on June 1, 2019.

## Appendix C: Management Comments

### Department of Veterans Affairs Memorandum

Date: October 7, 2020

From: Executive in Charge, Office of the Under Secretary for Health (10)

Subj: OIG Draft Report, Audit of Management and Oversight of the Electronic Wait List for Healthcare Services (Project Number 2019-09161-AD-0004) (VIEWS 03568048)

To: Assistant Inspector General for Audits and Evaluation (52)

1. Thank you for the opportunity to review the draft report on VHA's electronic wait list for Healthcare Services. I concur with OIG's recommendations and provide the attached action plans in response.
2. The Office of Veterans Access to Care (OVAC) has taken several steps to improve oversight of the Electronic Wait List (EWL). Upon learning that entries older than 24 months had been omitted from the EWL report, OVAC collaborated with VHA's Support Service Center to ensure these entries would be viewable. The report was updated in October 2018 and officially changed by November 1, 2018.
3. On August 6, 2019, OVAC updated VHA's policy on using and maintaining the EWL to require all administrative transfer requests be placed into the Light Electronic Administrative Framework (LEAF). Tracking these requests using LEAF allowed separation of administrative and clinical tasks. Additionally, LEAF has automated reminder processes.
4. On June 18, 2020, OVAC established a new process whereby sites are required to track clinical requests awaiting care using the clinical consult toolbox rather than through the EWL. The new process is outlined in OVAC's memorandum, "Implication of New Patient Scheduling and Elimination of the Veteran Health Administration Electronic Wait List."

*The OIG removed point of contact information prior to publication.*

(Original signed by)

Richard A. Stone, M.D.

Attachment

**VETERANS HEALTH ADMINISTRATION (VHA)**

**Action Plan**

**OIG Draft Report: Audit of Management and Oversight of the Electronic Wait List for Healthcare Services (2019-09161-AD-0004)**

**Date of Draft Report: September 10, 2020**

Recommendations/Actions Status	Completion Date
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**Recommendation 1. The Under Secretary for Health has oversight controls developed and implemented to monitor all facilities’ patient care requests that are identified as “unable to schedule” to ensure patients across the Veterans Health Administration are scheduled in a timely manner.**

**Comments:** Concur

Recent changes to support oversight of patient care requests that are identified as “unable to schedule” are outlined in “Simplification of New Patient Scheduling and Elimination of the Veteran Health Administration Electronic Wait List” dated June 18, 2020. This outlines further recommended processes to appoint Veterans and ensure tracking these requests without use of the Electronic Wait List (EWL). Recent efforts also included communication at VA Central Office (VACO), Veteran Integrated Services Networks and medical center levels of the organization about alternative processes that would facilitate oversight efforts to address “unable to schedule” in appropriate ways for timely high-quality clinical care of Veterans.

In addition to the memo and communications, the Veterans Health Administration will implement oversight controls developed to monitor all medical center patient care requests that are identified as “unable to schedule.” Primary monitoring and oversight responsibilities will be managed at the medical center and Veterans Integrated Services Network levels respectively. National program offices serve as a resource to support medical centers not meeting thresholds. The Office of Veterans Access to Care (OVAC) assumes oversight at additional threshold levels. There will be strong communication and reporting expectations. Regarding those entries on the “unable to schedule” list, the offices of Geriatrics and Extended Care and the Office of Mental Health and Suicide Prevention will work with individual medical centers to ensure appropriate disposition and care including in the Community, as applicable. OVAC will submit thresholds and monitoring tools to document completion of this recommendation.

Status: In progress

Target Completion Date: March 2021

**Recommendation 2. The Under Secretary for Health ensures standard operating procedures are being implemented so that facility employees routinely review and act on patient care requests identified as “unable to schedule” in the consult toolbox.**

**Comments:** Concur

OVAC and national program offices such as Geriatrics and Extended Care and the Office of Mental Health and Suicide Prevention will collaborate with Veterans Integrated Services Networks (VISNs) to ensure implementation of Standard Operating Procedures (SOPs) focused on utilization of the Consult Toolbox. Additionally, OVAC will collaborate with national program offices to set expectations for care when there are limited options in a medical center and when there is a lack of comparable service in the community. Emphasis will be placed on communication management and expectations for Patient Aligned Care Teams to monitor and manage Veteran care. Medical centers, VISNs, program offices and

OVAC will monitor “unable to schedule” entries and ensure that SOPs are clear, in place and followed. Trainings, webinars and other materials will be shared to ensure oversight controls are being sustained with VISNs and medical centers.

Status: In Progress

Target Completion Date: March 2021

**Recommendation 3. The Under Secretary for Health makes certain that facility leaders clearly define and oversee procedures on routinely reviewing, monitoring, and addressing transfer entries on the Light Electronic Administrative Framework.**

**Comments:** Concur

OVAC sent guidance to Veterans Integrated Services Networks (VISN) and medical centers for implementing updates to national policy on using and maintaining VHA’s EWL. OVAC’s memo dated August 6, 2019 outlines the process for identifying and tracking administrative transfers. Guidance was included in the recent update to VHA’s scheduling directive (published January 20, 2020) that requires medical centers who elect to administratively track Veterans receiving VA care who request transfer to another VA facility or provider to use the Light Electronic Administrative Framework (LEAF) tool.

Recommendations 1 and 2 ensure all other requests are in accordance with processes outlined above. OVAC and VISNs will continue to monitor transfer entries on a quarterly basis. OVAC will ensure follow up with sites to ensure appropriate transfers from one site to another site of care. A VA memo will be forthcoming specifying expectation medical center LEAF entries reported to VISNs and OVAC. This will serve as interim guidance until VHA’s scheduling directive is updated again.

Status: In Progress

Target Completion Date: March 2021

*For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.*

## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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